DOCUMENT RESUME

ED 070 005 CG 007 632

AUTHOR	Rogawski, Alexander S.
TITLE	Generic Training Program for Community Workers in Human Services. Model Career Development Program for Community Mental Health Workers.
INSTITUTION	University of Southern California, Los Angeles. Dept. of Psychiatry.
SPONS AGENCY	National Inst. of Mental Health (DHEW), Bethesda, Md.
PUB DATE	Mar 71
NOTE	36p.
EDRS PRICE	MF-$0.65 HC-$3.29
DESCRIPTORS	Career Opportunities; Community Health Services; *Community Services; Health Programs; Human Services; Indigenous Personnel; *Manpower Development; *Mental Health; Mental Health Programs; *Nonprofessional Personnel; Paramedical Occupations; Training; Training Objectives; Training Techniques; *Vocational Development
IDENTIFIERS	*New Careers

ABSTRACT

Paper One discusses a training program for community mental health workers which was developed utilizing the "New Careers" concept in which the poor are trained to serve the poor. The intention is to share the lessons learned through the generic training program with others engaged in New Career Training Programs. A description of the training facilities is presented followed by a discussion of the four phase training program. The second paper, on a model career development program, is a description of a program designed to increase relevant knowledge, develop specific skills, and foster attitudes appropriate for the provision of effective human services. The first part of the report is an introduction dealing with the needs, objectives, overview, and methods of training. The second part is concerned with curriculum and aspects such as understanding human behavior, crisis intervention, and working with groups. (Author/BW)

ED 070005

GENERIC TRAINING PROGRAM
for
COMMUNITY WORKERS IN HUMAN SERVICES

CG 007 632

DIVISION OF SOCIAL AND COMMUNITY PSYCHIATRY
DEPARTMENT OF PSYCHIATRY
UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF MEDICINE

U.S. DEPARTMENT OF HEALTH
EDUCATION & WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

FILMED FROM BEST AVAILABLE COPY

ED 070005

GENERIC TRAINING PROGRAM

for

COMMUNITY WORKERS IN HUMAN SERVICES

Division of Social and Community Psychiatry
Department of Psychiatry
University of Southern California School of Medicine

Alexander S. Rogawski, M.D. - Project Director
Hiawatha Harris, M.D. - Co-Director
Betty Edmundson, M.S.W. - Project Administrator
Sascha Kaufmann, Dr.P.H. - Research Associate
Marva Roddy, R.N.P. - Training Director
Bert Strauss, M.S.W. - Training Consultant
Maria Ortiz, S.S.A. - Training Coordinator
Emily Gibson, S.S.A. - Training Coordinator

March, 1971

National Institute of Mental Health
Grant Number 5 T21 MH11529-02

TABLE OF CONTENTS

		Page
I.	INTRODUCTION	1
II.	TRAINING FACILITIES	6
	A. Division of Social & Community Psychiatry	6
	B. Central City Community Mental Health Center	9
III.	TRAINING PROGRAM: HISTORY, PRESENT, AND FUTURE	15
	A. Preparatory Phase	16
	B. Phase I	20
	C. Phase II	25
	D. Phase III	30
IV.	SUMMARY STATEMENT OF ACCOMPLISHMENTS	31

A GENERIC TRAINING PROGRAM

FOR

COMMUNITY WORKERS IN HUMAN SERVICES

I. INTRODUCTION

For the past fifteen to twenty years research in the social and behavioral sciences has presented us with an enormous amount of data documenting the widespread mental health problems among the lower socio-economic segments of our society. At the same time, it demonstrated the inadequacy of the traditional mental health services and, in fact, of all human services available to disadvantaged populations.

The "New Careers" movement, the innovative idea of "hiring poor to serve the poor," appeared to many professionals, concerned citizens and legislators to be the most promising approach to the improvement of this dismal situation. Efforts in many parts of our country to establish a range of various New Careers projects were supported by enabling legislation evolving from the "war against poverty," notably the Scheuer-Nelson Subprofessional Career Act of 1966, an amendment to antipoverty laws which made funds available for the training and employment of noncredentialed workers in public services.

In recent years, many well-intentioned and often well-conceived New Careers programs have run into difficulties or faltered completely. A basic obstacle to the success of such projects is their enormous complexity, which surpasses the specialized competence of the several groups, institutions, and systems which must collaborate towards the common goal. Involved in New Careers programs are professionals in various human services, adminstrators, civil service specialists, legislative experts, community organization specialists and, last but foremost, the new careerists themselves.

New Careers developments have far reaching reform implications for many established institutions and systems: the current systems of delivery of health and social services; the organization, methods, and content of education; civil service regulations and bureaucratic hierarchies; traditional professional role models and prerogatives; relations between consumers and public service agencies. The introduction of new careerists seems to threaten so many different categories of people in their role identity, in their job security, and in their concepts concerning standards of service that, in spite of growing evidence of the soundness of the new approach and despite extensive verbal and token acceptance of New Careers programs covert and overt barriers are erected to foil their success. The frustration for those engaged in New Careers programs is so great and so consistent that many an effort is either abandoned or at least deflected from the original intent to such an extent that to all practical purposes the project becomes a failure.

For the past four years, the Division of Social & Community Psychiatry of the U.S.C. School of Medicine has been involved in the training of New Careerists as Mental Health Workers. A "Model Career Development Program" has been gradually developed, has received federal funding (NIMH Grant #11529), has survived its birth pains, and has been modified through experience.

The Division hopes, through this paper, to share the lessons learned during this process with others engaged in New Careers Training Programs. We have come to realize that an educational program for New Careerists is basically different from educational programs for the traditional types of students. In fact, the planning and organization of a curriculum, the provision of educational opportunities, i.e. the educational program itself is only a part of the total task of introducing and integrating community workers into human services:

A. A training program for new careerists must guarantee its students employment upon graduation. During the first year of our funding, we engaged in a thorough search for employment opportunities and found that, at least at this time, private organizations are either unwilling or unable to hire new careerists in appreciable numbers. In the six months since we terminated this search, conditions have become even more grim because of widespread budget retrenchments.

We had to turn to public services if we wanted to secure jobs for our students. With considerable effort, we established a close working alliance with the Los Angeles County Department of Personnel which is responsible for the introduction of hundreds of new careerists into county departments concerned with the delivery of human services.

The Department of Personnel has assisted us in obtaining new trainees for our program. These trainees are paid a modest stipend during their period of training from funds provided by one of several federal antipoverty programs (e.g. Concentrated Employment Project-CEP, Mexican-American Opportunities Foundation-MAOF, and Neighborhood Adult Participation Project-NAPP). All trainees are guaranteed employment in the county civil service system upon graduation from our program.

The Department has come to regard our training program as an important educational resource. It plans to apply our training model throughout the far-flung county organization if and when our research and their experience prove its value.

B. Success of a New Careers project depends on community contact and community control. Through consistent efforts and with much patience, we have established a warm and cooperative relationship with local community representatives such as the Mexican-American Opportunities Foundation, the East Los Angeles Health Task Force, and the Neighborhood Adult Participation Project. These organizations select the trainees and monitor our program and its effects. Feedback from these organizations and from other community representatives is integrated into the program.

C. Performance of New Careerists is dependent on their developing a sense of identity and pride which can be achieved best when they feel themselves members of a group or a team. Our project developed gradually and so the first participants entered the program at different times. This fact complicated our educational program. It led to morale problems for some students and made

research evaluation virtually impossible. We now insist that all trainees in new groups start training simultaneously.

D. Success in training New Careerists depends on the simultaneous orientation and preparation of their future employers, supervisors, and administrators. This important insight was gained after the first year; and appropriate methods were initiated to involve this group in our project. Joint meetings with new careers supervisors (trainers and employers) are held regularly. Contact is also maintained with the supervisors of program graduates to identify new problem areas. The Division has administrative responsibility for 14 of its own New Careers graduates. This provides us with first-hand experience in problems of supervision which is fed back into the training program. It has forced us to recognize that an important area where the New Careers program is tested is in the face-to-face contact of New Careerist with traditional careerist.

Insights gained in the first half of our funded project period have caused us to modify methods, format, and even goals of our project even though the basic purpose, i.e. the creation of a career development model for people from disadvantaged background, has been maintained.

The change in the title of the project from "Mental Health Aides" to "Community Workers in Human Services" expresses our new and broader orientation based on the realization that the problems and distress of the poor can be compartmentalized even less meaningfully than those of other socio-economic groups.

In keeping with this new orientation, we are educating our trainees in the generic aspects of human service in the hope that as graduates they will be able to employ their newly gained knowledge and skills not only in mental health, but in all kinds of service organizations: public health, community services, hospitals, law enforcement, probation, adoptions, and especially in public social services.

Recognition of the complexity of the New Careers concept has led us to create a novel collaborative arrangement between an educational

institution--the Division of Social and Community Psychiatry, Department of Psychiatry, U.S.C. School of Medicine--and a large governmental organization providing public services--relevant departments of the government of the Los Angeles county. This arrangement may serve as a model for similar projects elsewhere. More time is needed to firm up the relationship, to gather experience, and to evaluate and describe it. Initial acceptance has been rewarding.

Recognizing the importance of group influence on our trainees, we subdivided each new group of students into small workgroups to strengthen the new identity and to enhance individual performance. Also quite early in the training, we take the trainees to an isolated resort for a "sensitivity group weekend." This plus on-going interpersonal workshops seems to be very constructive for reinforcing group cohesiveness.

We are studying the effect of involving present and future supervisors in our program and of engaging community representatives in a collaborative relationship.

The insistence on all these basic requirements, i.e. the securing of a firm job, the simultaneous start of training of groups, the ongoing coordination with representatives of the community and the collaboration with all relevant agencies has caused much delay in our project. It has taken consistent personal involvement by all members of our team to achieve the acceptance of our program by the various sectors of the community involved with our students and graduates. Refusing to compromise the quality of the program has had important if unexpected side effects in improving our relations with community agencies and also with county administration. Sitting down together to solve common problems has opened communication channels and dispelled doubts as to the genuineness of our purpose and efficacy of our methods. Time for such planning and coordinating efforts must be allocated in advance. There is hardly an aspect of the program, whether training, job integration, or research, which has not required repeated conferences, clarification of misunderstandings, personal interventions, use of old friendships, and development of new trusts.

The experience has strengthened and enriched the residency program of the Division of Social and Community Psychiatry. It has linked the Medical Center more closely to the community, and improvements in the delivery of psychiatric services to the barrios and ghettos are already evident.

II. THE TRAINING FACILITIES

A. The Division of Social & Community Psychiatry

The Division of Social and Community Psychiatry in the Department of Psychiatry of the University of Southern California, School of Medicine was created on July 1, 1962, and has ever since been engaged in the education of various professional groups (psychiatric residents, interns, medical students, physicians, social workers, welfare workers, psychologists, psychiatric nurses, etc.), in mental health education for various community groups, in consultations to community caregivers and in research projects related to community psychiatry.

The Division is located on the premises of the Psychiatric Hospital, a component of the Los Angeles County-University of Southern California Medical Center. The Medical Center is the major clinical facility of the USC School of Medicine. Correspondingly, the Psychiatric Hospital and its various satellite facilities are the clinical facility of the Department of Psychiatry of the Medical School. Operationally, the Psychiatric Department of the Medical Center is divided into four clinical services:

1. The Adult Admitting-Evaluation and the In-patient Serivce

   a. The Admitting-Evaluation Service operates 24 hours a day and seven days a week, providing emergency evaluation and crisis intervention services, intensive evaluation, referral services, follow-up and after-care. Some 20,000 persons seeking help present themselves each year on their own or are

brought in by family, friends, or peace officers. They may also be referred by the courts. The unit is primarily responsible for the 2-1/2 million residents living in Area II of Los Angeles county and two adjacent public health districts of Area I. It must provide psychiatric assistance to anyone from this region who cannot obtain treatment elsewhere.

b. Anyone admitted to the In-patient Service is treated in one of seven hospital wards with a total capacity of 175 beds.

2. The Adult Psychiatric Out-patient Department is located in a special building about a mile from the Psychiatric Hospital and provides a large range of psychiatric diagnostic and therapeutic services to the community. Most patients are either completely indigent or have very limited resources.

3. The Adult Consulting and Liaison Service (Psychosomatic) provides psychiatric consultations, mental health consultations and educational services for the patients, physicians, medical students, interns and residents of the giant General Hospital (medical-surgical) in the Los Angeles County-University of Southern California Medical Center.

4. The Child-Adolescent Psychiatric Division is composed of a small Children's ward and a small Adolescent ward for the intensive residential treatment of psychiatrically ill children and adolescents, a Children's and Adolescents' out-patient clinic, an affiliated Child Guidance Clinic, and a Pediatric Consulting and Liaison Unit (Psychosomatic) at the Childrens' Pavillion of the LAC-USC Medical Center.

These rather heavy and comprehensive service obligations are combined with an extensive educational program offered by the full-time, part-time, and clinical staff of the Medical School and by the staff of the Department of Hospitals of the County of Los Angeles to resident physicians, physicians in postgraduate training, medical interns, clinical psychology interns and postdoctoral fellows, psychiatric social work students, student nurses, student occupational therapists, medical students, student recreational therapists, psychiatric technicians, and, since the inception of our program, also to new careerists. The atmosphere of our clinical facilities is imbued with a spirit of learning.

The LAC-USC Medical Center is situated at the very heart of one of the largest and most populous counties in the United States, with a population of almost 7 million. Some parts of the county, especially its Northern half, are sparsely settled but the heart of the county and the adjacent areas are densely populated and urbanized. The immediate vicinity of the Medical Center is a socio-economically depressed area dotted with neighborhoods which are often referred to as barrios because the residents are chiefly Mexican-American or of Mexican descent. They speak Spanish or are bi-lingual. South of the Center and slightly to the East is the border of Los Angeles' Central City, the Southern part of which is settled by a predominatly disadvantaged black population including many recent immigrants from depressed rural regions of the country's South.

The Medical Center is thus surrounded by people who must suffer the double jeoparody of poverty and minority status. A large percentage of the patients seeking help at the Psychiatric Hospital and its Out-patient facilities come from these population groups. The setting provides a strong incentive for the Division of Social and Community Psychiatry to focus on mental health problems of the poor and to explore ways by which the inadequacies of mental health services for the poor can be remedied.

The first candidates for training as mental health aides were introduced to the Psychiatric Hospital by the Division in January, 1967. On retrospect, it must be conceded that a huge and complex enterprise was tackled with a naivety worthy of those fools who rush in where angels fear to tread. Our knowledge and understanding concerning new careers were more than hazy. We felt that a humanizing influence was needed in our Psychiatric Hospital which was seen by many of its immediate neighbors as a frightful place, a fortress in which dangerous "nuts" were locked up and from which all decent people should try to stay away as far as possible. The hospital did not appear to be a place where one could obtain help but a punitive and cusodial facility. This impression was reinforced by the unfortunate fact that the hospital houses District Court #95 where involuntary commitments and cases of sexual offenders, drug abusers, and criminally insane are adjudicated. The therapeutic functions of mental health professionals, the purpose of psychiatric facilities were widely unknown to many residents of

barrios and ghettoes. Initially, we hoped that we could improve the public image of the Psychiatric Hospital by bringing people from the community in and enable them to observe what was actually going on in the hospital, what the functions of the doctors and of the other staff were and that mental patients by and large were not so very different from most people they knew. We hoped that these community workers would return to their neighborhoods as ambassadors of good will for the hospital and that they would act as out-reach people and early case finders for neighbors and acquaintances with psychiatric problems. We saw in our program an opportunity to bring the hospital and the community closer to each other.

It did not take long, however, for us to realize that our community workers were capable of performing much broader functions than we planned originally and that with some educational assistance, many of them were able to develop into highly desirable providers of mental health care. We also began to become informed about the national developments in the new careers movement.

We recognized that the education of our mental health workers would be considerably enhanced if we would expand their training area beyond the clinical areas of the LAC-USC Medical Center to a mental health facility in even closer contact with the surrounding disadvantaged population and offer an additional range of services. The Central City Community Mental Health Center accepted our invitation to become a co-sponsor of our training program on July 1, 1968.

B. The Central City Community Mental Health Center

The CCCMHC was founded in June, 1962, by a group of citizens indigenous to "Central City" of Los Angeles. These citizens recognizing the numerous social ills related to problems of mental health, were determined to help their own community to combat these ills through the development of a mental health center. It is a nonprofit organization partially funded under the Federal Community Mental Health Centers Act dedicated to giving a service of quality and dignity to the community. Today, the center is committed not only to serving its patients and clients, but also collaborating with individuals and agencies in the community, interested in devising and operating mental health education programs.

Starting from a part-time volunteer staff, the Center has grown to a clinical facility with a full-time paid staff which includes psychiatrists, psychologists, social workers, nurses, occupational and recreational therapists, as well as educational and occupational counselors. The staff has been selected for a full-time operation of a comprehensive mental health center. It is currently offering out-patient treatment, care in a day treatment center, emergency care, consultation services, education and assistance in community projects. The remaining dimensions of comprehensive care such as total and partial hospitalization, research and evaluation are in the planning and developmental stage. In addition to the services listed above, the Center attempts to meet needs as they are presented by residents of this area. It subscribes fully to the community mental health centers philosophy that there be no waiting lists and that no one in need of help is turned away.

1. Out-patient Services

Although an out-patient clinic operated by the Los Angeles County Mental Health Department is near the Center, the demands for services are much greater than can be met by both clinics. A large percentage of patients are referred from other agencies. The Center has developed a consultation service for other facilities to enhance their therapeutic effectiveness. By indirect services, the Center attempts to reduce the demands for direct treatment.

The following modalities of treatment are available:

a. Crisis Intervention
b. Brief Psychotherapy
c. Long-term Psychotherapy
d. Pre-care and After-care
e. Diagnostic Services
f. Family counseling
g. Ex-felon assistance
h. Drug abuse and narcotics rehabilitation

The overwhelming majority of the population of the Center's catchment area falls into the poverty category, therefore, primary emphasis is on problems of living. For the most part, people coming to the Center are in the throes of a crisis situation compounding other unsolved problems. Many patients can be treated according to the crisis model in a few visits, up to six, with the resolution of the acute problem and referral to other resources if necessary. The Center has made its availability for crisis intervention known to other agencies such as the Suicide Prevention Center, the emergency room at Los Angeles General Hospital, the Los Angeles County Department of Public Social Services, the Probation Department, Family Service Agencies as well as churches and schools. A 24-hour service is maintained arranging for emergency service and/or appropriate referral.

Where crisis intervention does not suffice, a clinic team reviews the indications for more extensive therapy, individual, group, conjoint, marital, family, combined drug- and psychotherapy.

To avoid the build-up of a waiting list of chronic patients, some are seen individually on a bi-weekly or monthly basis, others are placed in heterogenous groups, forestalling expensive hospitalization. Chronic patients are also seen in the drug clinic and the day treatment center and assisted in their rehabilitation in an occupational/vocational program.

The Center is in communication with Camarillo State Hospital, Metropolitan State Hospital and Los Angeles County General Hospital and participates in aftercare and precare programs for patients in its catchment area. The welfare of these patients requires close contact with the California State Departments of Social Welfare and Vocational Rehabilitation. These government agencies and other organizations utilize the Center's diagnostic facilities.

The structure of families living in this area is often corroded by poverty and by the absence of a father. The Center focuses on a wide range of programs designed to restore and strengthen the family reducing chaos and turmoil in the household. Families are always involved in the evaluation and the treatment of children

whether self-referred or referred by schools and juvenile authorities. The Center collaborates with other family service agencies in related matters.

2. Day Treatment Center

The Center operates the only day treatment center in this area. It is modeled after the ideas of Maxwell Jones' "Therapeutic Community" and functions as "a home away from home" to spare suitable patients total hospitalization and its implications. The facilities of the day treatment center are an important resource for the training of the community workers. They can observe not only traditional forms of group therapy but also family group therapy, psychodrama, etc.

3. Consultation Service

The Center is offering consultation to a variety of local public and private agencies and organizations. These consultations comprise the various categories of client or consultee centered case consultations and program or consultee centered administrative consultations. An effort is made to expand contractual arrangements to such services as the local police department, religious organizations, family service agencies, YM and YWCA, anti-poverty programs and various city departments. The model of consultative service to the police department, as described by Goodstein and Oseas in their paper "The Psychological Services Center" provides the basis for this Center's approach.

These services include the review of an organization's staff-selection program, the responsibility for courses and lectures on topics of human and community relations, specific case conferences, special problems affecting the effectiveness of the organization and evaluation of disturbed staff relations.

4. The Community Services Division

This service offers advice, active assistance, information, and referral guidance in a large variety of problems to residents of the catchment area as follows:

a. Welfare

The Center provides information and referrals to all those in need of services of social service agencies.

b. Senior Citizens

The Center provides meaningful activities for senior citizens, such as agency information, reduced carfare, club activities, trips, parties and other things.

c. Job Referrals

The Center provides an employment counselor to aid in employment problems for the unemployed, underemployed, and those people needing on-the-job training.

d. Housing Services

The Center provides a listing of available housing for rent or sale in the community.

e. Tutorial Services

The Center provides remedial education services for children and adults.

f. Friendship Club

The Center provides an opportunity for members of the community to mingle and share in social, cultural, and enriching experiences.

g. The Eagle

The Center provides a community newsletter. Its purpose is to motivate and to serve the items of interest

h. Malcolm X Center

The Center offers a community meeting place free of charge for use of community groups. In addition, the Malcolm X Center is the site of a year-round youth program designed to train future community citizens.

i. Ex-Felon Program (Central City "Bricks")

The Center provides a new concept in comprehensive services for ex-offenders designed to forestall the difficulties that plague them upon their return to society. All regular services are available to persons served by this program in addition to housing in a familial type atmosphere directed by the ex-felons themselves.

j. Drug Abuse and Narcotics Rehabilitation ("Kick")

This program is administered by a team of inactive drug addicts, and includes group and individual counseling plus a facility (3 beds at LAC/USC General Hospital) for medically supervised detoxification.

The Community Services Division assesses mental health components in the problems of its clients and, if necessary, refers them to the Mental Health Services of the Center. On the other hand, the patients receiving mental health care at the Center are referred to this division for assistance in areas listed above. Thus, the Center attempts to meet the combined goals of mental health and social competence.

The staff of the community services division also seeks to establish liaison and collaborative relations with organized community groups such as the Chamber of Commerce, service clubs, etc.

5. Training and Research

The CCCMHC opened its doors only a few years ago. Initial organization and the setting up of services have absorbed staff time and energies and at this moment no specific research projects have been set up. However, even the initial experience has created great interest in various research areas. The following projects are under discussion and contemplated for the foreseeable future: evaluation of the various treatment modalities, categories of treatment indications, psychosocial aspects affecting the Center's patient population, sibling and parent relationships in the disadvantaged family, method of marriage stablization.

Various training efforts with allied professions and nonprofessional groups are either under consideration or in the process of organization. Graduate student assistant (clinical psychology, social work) and staff from related agencies are invited to serve as assistants to the Center staff. School guidance counselors, employment counselors, rehabilitation specialists, medical students and psychiatric residents, public health nurses and health educators have an opportunity to learn about the mental health problems of the poor and their resolutions. The students in this form of internship rotate through various departments of the Center.

The Central City Community Mental Health Center was long aware of the tremendous potential usefulness of New Careerists in the Mental Health field. When the Division of Social and Community Psychiatry approached them concerning a training program, the project coincided with their own plans and they accepted the co-sponsorship with enthusiasm. Though both facilities are located in poverty areas, their difference in organization and primary focus, their difference in patient population contribute to the richness of the trainees' experience. The concerns and the needs of the two cooperating agencies complement each other.

III. THE TRAINING PROGRAM HISTORY, PRESENT, AND FUTURE

The Training Program developed very gradually from informal and modest beginnings. For two and one-half years, it remained unfunded and depended entirely on voluntary efforts of the staff of the Division of Social and Community Psychiatry, and the psychiatric facilities of the LAC-USC Medical Center.

Reflecting the growth of the program and the increase in experience and sophistication, four distinct project phases can be discerned:

Preparatory Phase: January 1967 to June 30, 1969

Although the project was approved by NIMH as of July 1, 1968, it remained unfunded for this entire period.

Phase I: July 1, 1969 to June 30, 1970

First year of NIMH support, completion of the training and graduation of all trainees who had entered the project before. Realization that future trainees would all be related to public services.

Phase II: July 1970 to June 30, 1971

NIMH support continues. Staff reorganization. Entering agreements with Los Angeles County Departments. Second group of trainees supplied by the Los Angeles County Department of Public Social Services. First tryout of the new program under research monitoring.

Phase III: July 1, 1971 to June 30, 1972

NIMH support continues. One or two additional trainee groups in training (depending on whether or not renewal of project is granted). Evaluation of training results and writing of summary report.

A. Preparatory Phase: January 1967 to June 1969

When it was first decided to introduce people of disadvantaged background as a new group of mental health workers into the Psychiatric Hospital and to provide them with some education in the mental health field no funds were available for the project. We approached the Neighborhood Adult Participation Project, an agency operating under the auspices of the Office for Economic Opportunities and asked them whether they were interested in sending us their "NAPP Aides" so that we could attempt to prepare them for Mental Health Aide careers. NAPP was most ready to cooperate with us and to continue the payment of a modest compensation to the Aides while they were in training with us. Unfortunately, our agreement was based on a misunderstanding: NAPP assumed that we would offer these trainees employment after they had completed the educational experience. We on the other hand took it for granted that we were

merely an educational facility and that at the end of training, our graduates would have no difficulties to obtain employment in either a public or a private facility. This misunderstanding did not surface for a long time, but when it did, it created enormous problems for all concerned. The matter was finally settled by the Hospital creating 14 permanent jobs for the earliest group of our students. These community Mental Health Workers are now a cadre available to the Division of Social and Community Psychiatry to assist in the education and supervision of new trainees.

The presence of the NAPP Aides and the growing recognition of their potential stimulated us early to attempt to develop a training model for this new category of mental health personnel. We assumed that our trainees would find employment in both private and public mental health facilities as well as in other community agencies if we could prepare them for such jobs by relevant education. We felt that they were uniquely qualified to establish good relations with patients of background similar to their own, that they could understand the problems of the poor better than the traditional mental health professionals coming most often from a middleclass background, and that they could,therefore, act as interpreters and human bridges between the poor and the middleclass mental health professional. This was also a time of tremendous expansion of various mental health programs, creating a scarcity of mental health professional manpower. The New Careerists seemed an excellent approach towards the easing of mental health manpower problems.

The training of Mental Health Aides began in January 1967, without the benefit of funding on the basis of voluntary cooperation and contributions of time and efforts by the Director of the Division of Social and Community Psychiatry and by the professional staff of the Psychiatric Hospital and its Out-patient facilities. The trainees were selected and referred to the program and paid a small stipend by several agencies which were charged with the recruitment and selection of New Careerists under federal sponsorship. These were, first, the Neighborhood Adult Participation Project (NAPP), under OEO; later, the Concentrated Employment Program (CEP), under the Manpower Development and Training Act, and the Mexican-American Opportunities Foundation(MAOF). These agencies were created in order to select appropriate

candidates for training, obtain commitment of public or private employers to hire the trainees after completion of their training, and to support appropriate training programs. Federal guidelines for New Careers stipulated that participants in New Careers training programs had to have jobs assured prior to their entering training and that federal funds be allocated for their support on a dimishing basis. Unfortunately, in the first year these obligations were poorly fulfilled by the referring agencies. People were referred to our training program without any assurance of employment after termination of their training. The selection was highly unsystematic. On the other hand, we were anxious not to screen out promising students by setting up minimum prerequisites before gaining more experience.

It is hard to describe the confusion which characterized the early period of our program. We were in a state of constantly recurring crisis, when support for our trainees was suddenly withdrawn, when positions could not be secured, when the lack of communication between various agencies and the lack of cooperation between representatives from county and federal authorities kept everybody in a state of frustration. Our problems were further compounded by the absence of a salaried staff for the training and supervision of a student population which required more training and more supervision than the traditional participants in mental health training programs. From the start, our trainees had to be taught the very ground rules of working in an institutional setting. They were frightened and confused by the presence of a large and constantly changing population of severely disturbed patients and they lacked the support which comes from preparatory training and structured roles.

Despite the complications merely alluded to, an outline of a training model was developed by the combined efforts of the Division Director and the psychiatric, social work, and nursing staffs of the Hospital. Each enrollee spent 40 hours each week in the clinical areas of the psychiatric hospital. Didactic material was presented to the trainees in 2-hour biweekly seminar sessions by the Division Director, invited professionals and guest lecturers.

The primary topics covered during this time and the percentage of total time allotted to them was as follows:

The Role and Function of the Mental Health Workers	35%
Public Health Issues (including problems of drug abuse retardation, and aging)	18%
Basic Concepts and Symptomatology of Mental Illness	16%
Community Mental Health Programs, Agencies, and Resources	13%
Mental Health Facilities, Programs, Legislation, Court Procedures	10%
Roles and Functions of Professionals in Mental Health	8%

Work experience was provided on the psychiatric wards and in the adult and children's out-patient departments. This practical training and supervision were rendered primarily by the nursing staff with the Division Director acting as consultant.

Although relationships between professionals and trainees were on the whole, quite good, lack of clarity regarding the trainees' specific roles and functions did create some training programs. For instance, ward attendants, who considered themselves a step above the trainees, felt threatened by the trainees and became envious of the special attention and training they were receiving.

In addition, the trainees were taken on field trips to various community facilities.

In order to provide the trainees with opportunities for engaging in mental health services in the community itself, the Division entered into a partnership agreement with Central City Community Mental Health Center described above.

All trainees were rotated through the Center.

Of the many difficulties which beset the program in the early days, two major problems stood out:

1. We found out that jobs were not readily available for our trainees, even when they had been "promised" to them. We learned that the concern for employment after termination of the training period was an essential responsibility of anyone involved in the education of New Careerists. Time and again, we met with people whose hopes had been raised by training program after training program only to be shattered when the training period came to an end. We were determined that this would not happen to our trainees. We did, in fact, finally succeed in securing employment for every trainee even though this took up an inordinate amount of the Director's time.

2. The absence of funds,and, therefore, of project staff, saddled us with the problem of a group of trainees who had come into the program at different times, and possessing different degrees of knowledge and experience, were at varying stages of their development. It was very difficult to transform these individuals into a single group, a feat that had to be accomplished in order to imbue them with a supportive role identity.

B. Phase I: July 1, 1969 to June 30, 1970

On July 1, 1969, the project received the financial support of NIMH Grant # MH11529. The information that funds were finally available arrived so late and so close to the start of the period that staff originally slated to participate in the project had disbanded and had found employment elsewhere. We had to reassemble a new project staff which included an assistant director whose functions combined planning, training, and administrative functions, a community organization specialist who was to scout for and secure employment opportunities both for the group of trainees in the program and for future graduates of the project; a training coordinator at Central City Community Mental Health Center, a training coordinator at the Hospital chosen from among the first group of trainees; a research associate; two consultants with previous experience in similar projects, and clerical staff consisting of a secretary.

Stipends for students were intentionally not included in the budget. We attempted to keep the total expenses of the program as reasonable as possible. We also wished to involve the future employer of our graduates in the program by assuming financial responsibility for the enrollees throughout their training period. The kind of students at which our program was aimed had to receive at least a modest remuneration to enable them to participate in the program. Poor people cannot afford to go to school on their own expense. We had to rely on the willingness of collaborating agencies to pay our students a stipend without expecting any services from them. This was only possible for agencies which were participants in federal antipoverty programs and which were reimbursed for their expenses. Even these agencies were reluctant to surrender trainees to us for more than half a year.

Thus, we had to plan our program for a maximum total of six months.

1. Classroom instruction was expanded from four to twelve hours per week. Lectures, lecture/discussions, and seminars covered the following topics:

Personality Development
Elementary Psychopathology
Interviewing and Case Reporting
Crisis Intervention
Group Dynamics and Group Process
Community Organization & Community Resources

The seminars were conducted by project staff and by guest speakers.

2. Field trips to community agencies were continued.

3. All students participated in weekly sensitivity training sessions. Each trainee could request individual counseling for personal problems with professional senior project staff and was referred to treatment staff of the out-patient department if necessary.

4. Practical experience, a minimum of 12 hours per week, was provided in various clinical settings of the psychiatric hospital; in the adult and children's out-patient clinic, in the community information services concerned with referral and residential placement, in the admitting and evaluation areas, and (by more recent arrangement)

in the psychosomatic service of the general hospital. Phase I trainees had also the advantage of gaining additional clinical and community experience at the Central City Community Mental Health Center where they worked in the admission area in the day treatment center and the multipurpose service center.

5. In keeping with legal requirements of New Careers programs, Phase I trainees obtained remedial and/or supplementary education. They attended a special high school and various community colleges for up to twelve hours each week.

Since January, 1967, a total of 42 trainees enrolled in the Model Career Program. Of these, 21 entered in Phase I, that is, after the program was funded. Entrance qualifications were still kept low so that potentially successful candidates would not be screened out. Twenty-six enrollees were Mexican-American, 15 were Blacks, and one was Caucasian. The majority were unmarried (single, divorced, separated, or widowed) women between the ages of 20 and 56. The enrollees' educational level ranged from 3 to 14 years of formal schooling and averaged 9.8 years.

Of the 42 trainees enrolled in the Program, 25 completed the training and 17, either left the Program voluntarily or were referred to other New Career programs at the recommendation of Program Staff. All new trainees had employment assured with public agencies before entering the Program. For the original group, employment had to be procured through the efforts of Program staff. At the end of their training period, all graduates obtained permanent jobs. Twenty-two graduates obtained employment in public human services: in the psychiatric department of the Medical Center, in welfare, and in probation. Three graduates were employed by private facilities: one became the director of a Catholic youth agency, another was placed in charge of a geriatric program at a community mental health center, and a third initiated an aide program at a privately-funded children's hospital.

Supervisors of the agencies in which Program graduates have been working for over six months report that, with exception

of two wh left their jobs for personal reasons, all our graduates perform their jobs satisfactorily and some perform them superbly. Program graduates are particularly highly valued at the Medical Center where they initiated, instituted, and solely maintain such long-needed services as interpreting for Spanish-speaking patients, conducting therapy groups in Spanish, making home visits, and personally escorting patients to various community agencies. The Program has apparently stimulated the graduates to continue their education inasmuch as close to one-half are currently enrolled in community colleges, working toward AA degrees.

Our follow-up of "dropouts" is still in progress. At this time, data support the impression that the "average dropout" was male, more highly educated and younger than those who remained in the Program, more likely to be Black than Brown or Caucasian, had a poorer attendance record, and was, in the opinion of some Program Staff members, both less mature and less encumbered or supported by familial and/or financial responsibilities than the other trainees. It also appears from informal conversations that some of the "dropouts," considered the Mental Health Aides' role "a woman's job" and the $2.00 an hour training stipend demeaning. We felt at first that our 40 percent dropout rate was much too high until we learned that other New Careerists at the Medical Center (well over 100) left their programs at a rate of more than 60 percent.

Much valuable experience was gained by the Staff in the first year of funding. What had appeared a simple project at the outset, turned out to be a rather trying effort in its execution, fraught with unexpected complications. Administrators and, even more so, mental health professionals welcomed our efforts at first. The performance of our trainees with patients drew many positive and endorsing comments. However, as the project progressed, it became necessary to secure jobs for those without previous commitments, bureaucratic barriers and

professional resistance created serious obstacles. Uncertainty over obtaining jobs and envy of trainees whose jobs had been secured, badly affected the morale. Absenteeism, lateness, and intragroup tensions became serious problems. Much staff time was deflected from the primary goals of teaching and had to be spent on efforts at mediation and trouble-shooting as well as on reassuring our students. Nevertheless, we were successful in creating a number of new positions at the Medical Center where, as described above, our graduates now perform valuable liaison services between the hospital and the community.

The survey of local job opportunities by our community organization specialist revealed that most private agencies were reluctant to introduce budget items for New Careerists. At this moment, there are virtually no jobs available in the private sector. If acceptance is to be gained for New Careers programs, we shall have to stress employment of community workers in publicly-funded agencies which respond more readily to community demands. The community can exert political pressure for innovative programs and for the employment of people from disadvantaged and minority groups in public human services. In order to facilitate the integration of New Careerists into established facilities, employer agency and supervisorial staffs will have to be oriented in advance and assisted concurrently in the management of problems arising from employment of this new kind of manpower.

The Project Staff has been participating in several regional and national conferences to exchange experiences with other teams involved in the education of New Careerists. At a recent meeting of the American Orthopsychiatric Association, our Staff initiated and conducted a workshop on "Resistance by Agencies and Professional Groups to the Introduction of New Careerists." The workshop brought to light many apprehensions and resentments in professionals and nonprofessionals alike. It culminated in the passing of a resolution urging the Executive Council of the Association to admit qualified New Careerists to its membership and to invite New Careerists to all proceedings on matters concerning them. This resolution has been acted upon affirmatively.

C. Phase II: July 1, 1970 to June 30, 1971 (Current Program)

A thorough evaluation of our accumulated experiences during the first year of funding has enabled us to make Phase II of the Training Program much "tighter," more polished, and altogether more relevant for both the trainees and their future employers. We now receive our trainees through a special Manpower Utilization Section of the Los Angeles County Department of Personnel. Two kinds of changes have been made in the Program to improve trainee morale and to reduce dropout rates: those which have been instituted with a view to maintaining the integrity and successful continuation of the Program (administrative changes), and those which have been made in the Program itself (substantive changes).

1. Administrative changes have been both intrinsic and extrinsic to the Program. As a result of a major reorganization of the Project Staff structure, we redistributed functions and responsibilities as follows:

a. The Project Administrator has been freed from primary training responsibilities. She is responsible for coordinating all aspects of the complex program to insure smooth operation among the many organizations and agencies involved. She supervises the Phase I graduates now working at the Medical Center, who act as role models and trainers for Phase II enrollees.

b. The Training Director is responsible for all aspects of the training including those which occur in practical settings and come under the immediate purview of agency supervisors.

c. Two Training Coordinators, one at the Medical Center and one at the Community Mental Health Center, provide on-the-job supervision and offer emotional first aid for the students.

d. The full-time Research Associate evaluates the Program's effectiveness, is responsible for a running record of all developments and researches the implications of the Program on:

(1) The Trainees/graduates

(2) The agencies in which the Trainees are training and working.

Extrinsic administrative changes were made to improve and strengthen the vital relationships that must exist between a Program like ours and the various community agencies and programs with which it articulates. In contrast to conditions during Phase I, we now have established a close cooperative relationship with the Los Angeles County Department of Personnel, particularly (and most importantly) with its Employment Opportunities Division, which integrates and administers New Career program activities for the entire Los Angeles County government. We have completed an agreement with the Los Angeles Department of Public Social Services through which our graduates will be employed by DPSS as Social Service Aides. After they have completed their training, we are authorized--in adherence to our research and evaluation plan--to follow our graduates' progress on-the-job as well as to compare it with Social Services Aides who started on-the-job training at the DPSS at the same time without going through a formal training program. A comparison of the effectiveness of our graduates with this control group will inform us as to the value of the training model.

The Program has undergone several major changes. When we first planned the project, we intended to train our students specifically for work in the psychiatric and mental health field and we called our graduates "Mental Health Aides." We have ceased to call them Aides because this term has a demeaning ancillary significance. They often work quite independently even though they can rely on the back-up of professionals. We dropped the name "Mental Health" in their title. Our graduates are referred to now as "Community Workers." Our current hypothesis is that any human service worker whether in welfare, correction, education, etc. will in the course of his activities meet with more or less severe mental health and psychiatric problems in people not necessarily designated as psychiatric patients. Six months of preparation in generic topics and basic interpersonal skills will prepare these human service workers for jobs in their definitive assignments. There they will complement our generic training with special on-the-job education. The assumption that such preparation will result in appreciably greater competence will be tested in the coming year.

2. Training Program In Phase II

Based on the experience in Phase I, the "academic" flavor of instructional materials and presentations in the training package was greatly reduced.

Our new Training Director wishes to "start where the trainees are at" to foster "learning by doing" and to encourage the trainees to draw on their personal experiences whenever possible. The aim is to help students not only to gain knowledge and techniques but to assist them in their personal growth.

The change in orientation and focus of the training is unquestionably influenced by the professional background and the personal characteristics of the Training Director. Whereas training in Phase I was organized by a clinical psychologist with much didactic experience with professionals, training in Phase II was reorganized and reformulated by a psychiatric nurse with much experience as nursing instructor, and knowledgable in new concepts and techniques of education.

The new Training Director has the added advantage of being a Black professional, who can communicate effectively with trainees, and serve as a role model for them. By using Black and Mexican-American New Careerists and professionals as teachers, training coordinators and workshop leaders, the project demonstrates that positions of responsibility are open for the trainees when they achieve similar levels of competence.

The training program now consists of the following components:

Classroom instruction....12 hours per week
Practical experience.....12 hours per week
Remedial and/or supplementary education...12 hours per week.

Classroom instruction in seminars, occasional lecture/discussions, group discussions simulations, role playing, video assisted instruction will again be combined with structured field trips to a series of relevant community resources.

The new curriculum covers the following topics:

Working in the Field of Human Services

Understanding Human Behavior

Crisis Theory and Intervention

Interviewing and Reporting

The Community and Its Resources

Working with Groups

Guest speakers are invited as during the earlier phases. In Phase II, they are drawn more than previously from community agencies in which graduates will be training and subsequently working. Practical experience is continued in all areas of the Psychiatric Hospital, in the psychosomatic service of the General Hospital of the LAC-USC Medical Center, and at Central City Community Mental Health Center.

The following changes are expected to reduce trainee dropout rate (particularly that of male trainees):

a. The firm policy to train and graduate one group of trainees at a time rather than to permit new trainees to "trickle in" in small groups, as they did during Phase I;

b. The intention to place male trainees into training and working situations where they will be overseen by male supervisors, whether these be nurses, social workers or other human services professionals; and

c. The employment of an outside sensitivity group leader, who specializes in leading sensitivity groups composed of New Careerists. He will conduct "Interpersonal Workshops", to replace sensitivity training groups previously conducted by a member of the senior project staff. In order to promote group cohesion and group spirit, the incoming trainees spend a workshop weekend with their group leader in an out of town retreat.

3. Research Program

The research and evaluation plan has been redesigned to evaluate:

(1) The Program's effect on the Trainees' level of knowledge, particularly in regard to normal and abnormal human behavior, as well as on their attitudes and general life orientation toward themselves and others;

(2) The Program's effect on the training agencies, particularly on their social systems, and

(3) The Program's effect on the employing agencies, again, particularly on their social systems, but also--though it may not be possible to research this until Phase III--on the ways in which these agencies provide human services.

We are testing the hypothesis that, compared to a grossly matched group of New Careerists who will receive immediate on-the-job training at the Los Angeles County Department of Public Social Services, our Community Workers will be:

(1) Significantly more sophisticated about all forms of human behavior,

(2) Will be significantly more skillful in dealing with human beings under stress and in crisis, and

(3) Will therefore be significantly more effective human services workers in the evaluation of the employing community agency and the clients they will be serving.

In an effort to maximize the reliability (and hopefully also the validity) of the data, specifically, to establish (1) whether New Careerists are different from the poverty mainstream, and (2) whether the changes occurring in the two trained groups are due to their respective trainings or simply a function of daily living, we shall also be "evaluating" a group of persons from the community (grossly matched to the two experimental groups). For the purpose of obtaining as much in-depth information as possible, we are limiting ourselves to training only one group of no more than 15 persons. However, we intend, subject to the outcome of our research and evaluations, to increase the number of trainees as well as the number of training classes in Phase III.

D. Phase III: July 1, 1971 to June 30, 1972 (Immediate Future)

During the final budget period, the training program will be modified by employment of newly gained experience. Research data on the effect of the program on the trainees and agencies will be collected and processed, and the results of evaluative research will be disseminated.

An expansion of the training program is planned both as to numbers of trainees enrolled and also as to types of agencies employing the trainees. The basic assumption underlying the training model is that a generic body of knowledge and skills are required for work in the field of human services regardless of the type of agency. During the first two phases of the program, New Careerists were trained for employment in psychiatric hospitals, psychiatric out-patient clinics, probation and welfare departments. Our intent is to broaden the applicability of our training by offering and testing it in as many new settings as possible. The program's success has been acknowledged and publicized by the Los Angeles County Personnel Department. Requests for training have been received from new sections of the Department of Hospitals and interest has been shown by representatives of other agencies. We wish to meet these interests.

A very fortunate opportunity has presented itself to us. The Department of Public Social Service is setting up an experimental district in the Lincoln Heights area close to the LAC-USC Medical Center. In the offices of this district, social services will be provided exclusively by indigenous nonprofessional staff. This represents an opportunity for a large scale test of one assumption of our program, namely, that indigenous human service workers can improve the quality of services best when they are functioning in their own community. To exploit the opportunity of testing the career development model in these various settings, we will require an increase in the number of training classes. Experience has shown that the classes must remain small in order to develop group cohesiveness and involvement by the trainees. Rather than expand the size of the classes, we are planning for at least two six-month classes during Phase III.

The evaluative research previously described is beginning at the present time. Testing, interviewing and performance evaluation of trainees involved in the test groups should be completed approximately one year from now (December, 1971). The evaluation effort thus overlaps Phase II and Phase III and sufficient time is allotted for processing, documentation, and dissemination of results before the termination of the project.

IV. SUMMARY STATEMENT OF ACCOMPLISHMENTS

A. During the first year of funding (July 1, 1969 to June 30, 1970) 25 Mental Health Aides (old title) or Community Workers (new title) graduated from the program. All of them are currently permanently employed.

14 workers...by the Los Angeles County Department of Hospitals

6 workers...by the Los Angeles County Department of Social Services

2 workers...by the Los Angeles County Probation Department

1 worker ...by the Catholic Youth Agency (Director)

1 worker...by the Children's Hospital

1 worker...by the Central City Community Mental Health Center (Director of Senior Citizens Program)

B. The curriculum has been repeatedly changed to make it more fitting to our type of students. We moved from the academic format to a focus on the relevant. In the new curriculum educational objectives are spelled out in clear operational terms. This allows for constant monitoring of the student's progress.

C. An educational program for New Careerists can only succeed if every student knows that a job is waiting for him. We established

a close liaison with the Los Angeles County Department of Personnel, the locally most significant potential employer of New Careerists. Their staff coordinated our program with the various Departments of the County involved in the delivery of human services. All trainees in our program know at the time that they begin their training that they have secure jobs if and when they complete the course successfully.

D. We have achieved a good collaborative relationship with various community representative organizations such as MAOF (the Mexican-American Opportunities Foundation), NAPP (the Neighborhood Adult Participation Project) and the East Los Angeles Health Task Force. These organizations select our trainees from the community pool. We consult with them on issues of training and research. In this way, we have introduced community control over the project and enhanced its potential relevance for our ultimate target: the poor in need of human services.

E. We are involved with a new group of 14 trainees who are slated to work after graduation in the Los Angeles County Department of Public Social Services. We have a close collaboration with the Department's administration to permit us:

1. to conduct simultaneously with the training of our workers an orientation of their future supervisors;

2. to set up a matched control group of new careerists who will not pass through our program. They will be compared with our students so that we can evaluate the effectiveness of the training program.

F. The Division staff was able to prevail upon the Los Angeles County Department of Hospitals to create 14 NEW positions for Community Workers which are all filled by our graduates.

These workers are placed in psychiatric in-patient and out-patient areas and on the psychosomatic service (especially suicide ward). The workers orient patients and their families on hospital procedures

and therapeutic programs; they motivate patients and their families to participate in therapeutic activities; they attend conferences and ward meetings; conduct counseling groups with patients; report observations of patients to the staff; interpret for patients and interpret to patients professional interventions; they make home calls before and after discharge of a patient; involve patients in community activities; take patients on shopping trips, outings and to health or social agencies; they help with the filling out of forms and act as advocates or brokers for patients. The reports by patients and staff on the activities of our graduates have been consistently favorable. The development and growth of these participants in our program could not be properly evaluated because they entered the program at different times and were often delayed in their definitive integration into employment by administrative and bureaucratic barriers.

G. Careful planning and preparation in the first half of the second year of funding (July 1 to December 31, 1970) has now created the necessary basis and the controlled conditions for a research evaluation of the training effort.

H. The project staff has participated in several local, statewide, and national meetings concerned with issues of new careers. The project director is currently the chairman of a Study Group of the "Pre- and Paraprofessional New Careerists and the Nontraditional Professionals" of the American Orthopsychiatric Association.

The project director also planned, arranged and chaired two national workshops on new careers during Annual Meetings of the American Orthopsychiatric Association. As a result of this meeting, the Board of the American Orthopsychiatric Association decided to admit qualified New Careerists to its membership.

I. Project experience has shown that basic psychiatric and mental health experience can be useful not only for Mental Health Workers in the narrow sense but to workers in all types of human services. We, therefore, changed the title of the project from Model Career Development Program for Mental Health Aides to Generic Training Program for Community Workers in Human Serivces.